

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 1639

JAN 23 1951

|  |                                  |  |   |  |                                    |   |                            |
|--|----------------------------------|--|---|--|------------------------------------|---|----------------------------|
| BIRTH NO. _____  |                                  | REG. DIST. NO. 170   |   | PRIMARY REG. DIST. NO. 3033  |                                    | Registrar's No. 409   |                            |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Sacreda</u>  |                                  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Mo.</u> b. COUNTY <u>Sacreda</u> |                                    |   |                            |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <u>Lebanon</u>   |                                  | c. LENGTH OF STAY (in this place)<br><u>1 mo.</u>  |   | c. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN <u>Lebanon</u>   |                                    | 0532  |                            |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>286 Michigan</u>  |                                  |  |   | d. STREET ADDRESS (If rural, give location)<br><u>286 Michigan</u>   |                                    |   |                            |
| 3. NAME OF DECEASED<br>(Type or Print)   |                                  | a. (First) <u>Vera</u>   |   | b. (Middle) <u>Mary</u>  |                                    | c. (Last) <u>Kuhn</u>   |                            |
| 4. DATE OF DEATH   |                                  | (Month) <u>Jan.</u>  |   | (Day) <u>17,</u>   |                                    | (Year) <u>1951</u>  |                            |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><u>Never married</u>   | 8. DATE OF BIRTH<br><u>Nov. 8, 1950</u> | 9. AGE (In years last birthday)  | if UNDER 1 YEAR<br>Months <u>2</u> | if UNDER 24 HRS.<br>Days <u>9</u>   | Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Infant</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><u>Ft. Riley, Kansas</u>  |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                       |                            |
| 13a. FATHER'S NAME<br><u>Wm. R. Kuhn</u>   |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>Celerina Legleiter</u>   |   | 14. NAME OF HUSBAND OR WIFE  |                                    |   |                            |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No.</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>—</u>  |   | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><u>Wm. R. Kuhn Lebanon, Mo.</u>   |                                    |   |                            |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.   |                                  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Enlarged thymus gland</u><br>ANTECEDENT CAUSES<br>Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><br><u>273X</u> |   |  |                                    | INTERVAL BETWEEN ONSET AND DEATH<br><u>Less than one mo.</u>                        |                            |
| 19a. DATE OF OPERATION   |                                  | 19b. MAJOR FINDINGS OF OPERATION   |   |  |                                    | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                            |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)   |                                  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)  |                                    |   |                            |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)<br><u>1-11-1951</u>  |                                  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21f. HOW DID INJURY OCCUR?   |                                    |   |                            |
| 22. I hereby certify that I attended the deceased from <u>1-4-</u> , 19 <u>51</u> , to <u>1-17-</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>1-11-</u> , 19 <u>51</u> , and that death occurred at <u>1:00 A.M.</u> , from the causes and on the date stated above. |                                  |  |   |  |                                    |   |                            |
| 23a. SIGNATURE (Degree or title)<br><u>B. B. Huist, M.D.</u>   |                                  |  |   | 23b. ADDRESS<br><u>Lebanon, Mo.</u>  |                                    | 23c. DATE SIGNED<br><u>1-17-51</u>  |                            |
| 24a. BURIAL: CREMATION, REMOVAL (Specify)  |                                  | 24b. DATE<br><u>5/17/1951</u>  |   | 24c. NAME OF CEMETERY OR CREMATORY<br><u>St. Fidelis</u>   |                                    | 24d. LOCATION (City, town, or county) (State)<br><u>Victoria Mo.</u>                |                            |
| DATE REC'D BY LOCAL REG.<br><u>1-17-1951</u>   |                                  | REGISTRAR'S SIGNATURE<br><u>Hella L. May</u>   |   | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>No funeral director</u>   |                                    | ADDRESS   |                            |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Received ..... JAN 20 1951  
Laclede County Health Unit  
File No. .. 1-21-18 .....  
Date Filed ..... JAN 22 1951 .....

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by .....  
..... Student Embalmer No. ....  
working under my personal supervision. *No Embalming*  
Student ..... Signed *William A. Fulk*  
Student Embalmer

Licensed Embalmer No. *4658*  
P. O. Address *Lebanon, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.